

# EXHIBIT MM

Kristen Nathe <kristen.m.miller@gmail.com>  
Sunday, December 11, 2011 6:44 PM  
David Koon  
Fwd:  
12.7.11.docx; ATT00001.htm

Attachments:

Dr. Koon, I'm sorry this is so late. I sent it to Hoover first to make sure it was in line with what was expected. There may be things that I have missed or did not over hear, but this was my recollection of events. I apologize for the situation and have certainly learned the reiterated value of communication. I will always make an effort to improve my relationships with nursing staff and my patients in the future.

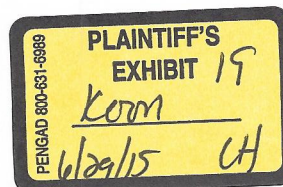
Kristen

Sent from my iPhone

Begin forwarded message:

**From:** Kristen Miller Nathe <kristen.m.miller@gmail.com>  
**Date:** December 9, 2011 4:49:16 PM EST  
**To:** "kristen.m.miller" <kristen.m.miller@gmail.com>

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This is my understanding and knowledge of what happened on 12/7/11:

11:30 am phone call on my cell from Catherine Loflin (general surgery) about two consults in the ED with open fractures. Was on my way in from prison clinic and stopped by the OR to pick up the call pager and change. Told Dr. Jones that there were two consults and he told me to see the patients, order XR, and come back when the XR were uploaded.

11:45 saw the critical patient (TF 374) in the trauma bay and CT 2. That patient was transferred straight to STICU. Ordered the proper x-rays.

12:15 went to evaluate TF375, but patient was in CT3. Patient started in trauma bay 1 and was transferred to CT3. General surgery wanted to get bilateral lower extremity CTAs and the CT scanner was having problems, taking longer than normal. Followed the patient back into trauma bay 1 where x-rays were taken that I ordered while in CT. After x-rays, the patient was moved to ED room 254. When the patient was taken back to the trauma bay after CT is when I introduced myself to the patient.

12:30-1ish checked on results of CTs and x-rays and performed an H&P on TF375. Also went up to STICU to perform a more extensive survey of TF374. TF374 was hypotensive and her x-rays were deferred until later. Paged Whiteside. He called back and said since he was at Baptist that I should page Hoover. Paged Hoover once, no return call. Waited approximately 5 minutes then decided to talk to Dr. Jones.

1:15-1:30 when to priemer ortho clinic to discuss x-ray reads and injuries with Dr. Jones. Wood was in the clinic and overheard the injuries. She instructed me to page Irani to help with the consults. Dr. Jones gave a list of things to start with (wash out, reductions, and splinting for both patients) and check back when x-rays of TF374 were completed. Stated that depending on general surgery consent he would like to take TF375 to the OR that night. No discussion as to what would be fixed or done in the OR.

1:45ish headed back down to the ED. At that time, general surgery asked that the patient's family be removed from the ED room and placed in the consultation area. General surgery and a patient liaison asked me to speak to the patient's family to update them on the injuries and current plan. I spent approximately 10 minutes with the family, answered all questions to their satisfaction. After talking with the family, I discussed the injuries with the patient and immediate actions that would need to be taken including splinting the right ankle and left arm.

2pm Paged Irani. Called the ortho tech (Toni) and grabbed the C-arm to be used for reductions. At this point the patient's nurse, Elaine, asked me to consent the patient for the reductions. I responded that I had never consented a patient for reductions when not involving sedation. She told me it was protocol so I said I would. She went to get the forms. I never heard back about the consent paperwork. Irani introduced himself to the patient and described what needed to be done in the ED, reduce and splint her right ankle and reduce and splint her left arm.

The small room was set up with the c-arm at the end of the bed. In order to pass to the other side of the bed, the c-arm needed to be moved and replaced. The ortho tech was working with a small area nearest to the door, trying to help. The small room caused the ortho cart to possibly be in the way of entry of the room at times. We started by placing 4 chuck pads under the right leg with a trail into the trash can to try to minimize a mess. 10cc of 1% lidocaine was injected into the right ankle joint for pain control. The patient was also given 75mg of Fentanyl, she had received at least 150mg in the trauma bay. General surgery had instructed me not to use sedation. Irani then used 2L sterile NS to wash out the 3 cm lac over the medial malleoli after the lidocaine had time to take effect and the fentanyl was given. After the washout, the lac continued to slowly drip with a little on the floor after the trashcan had been moved. Fluoro was used to plan the reduction. Adaptec was placed over the wound with 4x4s then soft roll to keep it in place. Bulky jones was used for padding and then a short leg trillam splint was applied under fluoro. The reduction was hard to maintain. The reduction was checked after the splint dried under fluoro. I attempted the reduction and molded the splint. The sheets on the right side of the patient's bed were soaked with water even after attempts to prevent this from the washout. At some point during my molding, infusion tubing disconnected and I pointed out to the nurse, Elaine, that the patient's transfusion was leaking all over the patient and the bed. The c-arm was moved so the nurse could get to the line. During the right leg, the only comments that I can remember that could be construed badly were: Irani said "this reduction is difficult. That's as good as its gonna get, splint it there. It will be stabilized in the OR."

Next, Irani told the patient that we needed to fix the arm. He asked if she was doing ok and she said yes. As I cleaned up the right side of the room and remnants from splinting, Irani placed the patient in finger traps with no weight applied as directed by Dr. Jones to help in the left forearm and elbow reductions.

At one point, Elaine, was blocked in the back of the room by the C-arm, however, it was not asked to be moved so she could exit. No one had to crawl on the floor under the c-arm to pass. It was moved at least twice for nurses and myself to pass by.

Next, Irani placed chucks under the left arm trailing into the trash can. He used 2L NC to wash out the lateral lacerations to the elbow. We then padded the left arm and measured the long arm posterior slab. I attempted reduction of the elbow and checked it with fluoro. 2-3 attempts continued to show the elbow with subluxation of the radial head. The posterior slab was applied and I held the elbow in reduction while it hardened. Then the sugar tong splint was applied after that. I continued to hold the reduction and mold the sugar tong. At some point I said, "the elbow keeps popping back out, I am trying to hold it in with my mold."

After the left long arm splint hardened, the patient fell asleep for a few minutes while we were cleaning up the room. In regards to pain control, Irani and myself advised the patient before we started with the ankle reduction to tell us if she was having any pain and we would stop and get more pain medication. The patient never told us she was having pain, never cried out, never jerked limbs to pull away

from painful stimuli. The patient did cry when given her diagnoses and was concerned that she would not be able to run again.

The ortho tech, Toni, and I then placed the patient in bilateral knee immobilizers per Dr. Jones. The Hare traction on the left side had to be removed and the immobilizer had to be placed over her trileam splint on the right. Afterwards, we both helped the nurses roll the patient to change the bed sheets. The wet sheets were delayed being changed because the nursing staff had come in to tell us that they would prefer to only change it once and she was heading to the ICU. At that point, she had a bed but it was still occupied in the ICU. A few minutes later another nurse came in and said that she had a bed and was moving up to the ICU immediately. A few minutes after that, another nurse came to say she was going straight to the OR and we (Irani and myself) needed to consent her for surgery. At that point, Dr. Jones had not discussed surgery with us or what procedures he would like the patient consented for. Meanwhile, the patient was asking to see her family.

After finishing the reductions and splinting, Irani went to talk to the family and escorted them into the patient's room. Irani and myself were then asked to step into the trauma bay with a nurse manager (Arlene) and Elaine. My understanding of the concerns that they expressed were: 1. that things seemed unorganized and that the patient did not seem to know what was going on 2. that the patient wanted to see her family 3. needing consent for the reductions. The nurse manager stated that the reductions and splinting was not something that should have been done in the ED. The nursing staff did not stop Irani or myself at any point to suggest that the patient may need more explanation as to what was happening during the reductions. The nurses asked what pain medication was given, however, did not seem to give concern that the patient did not have adequate pain control.

The process of splinting took 1 hour and 15 minutes to 2 hours to complete. Honestly, I never checked the clock because I continued on to the next patient in the STICU.

I was focused while holding my reductions and molding. I can sometimes be unaware of what else is going on during those times. I may have missed conversations or actions by others during that time.

In my opinion, I felt that I worked as quickly and efficiently as possible to accommodate all of the patient's injuries at my level of education while keeping the patient informed of what was going on. I realize that there may have been a lack of communication between nursing staff and myself. I would appreciate the opportunity to work with them on correcting the communication barriers. I was unaware that Dr. Jones was called down to the ED and that there was any concern over comments made around the patient. In the future, I would love to be directly notified of any concerns so that I can attempt to understand, and correct my actions.